Schmieding /ILC Solutions Forum on Elder Caregiving

June 2, 2005 ♦ 9 am -12 noon

Schmieding Conference on Elder Homecare

June 2, 2005 ♦ 12 noon - 4 pm

REPORT OF FINDINGS

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REINVENTING NURSING HOMES AS "HOME"

Modernizing nursing homes from warehouses to an "in-home" approach can improve the quality of care and lower costs

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SOLUTIONS FOR KEEPING ELDERS AT HOME FOR LIFE

TESTIMONY OF DEE ANN BEEBY, MA, CCC-SLP, CMC TO THE POLICY COMMITTEE OF THE WHITE HOUSE CONFERENCE ON AGING

I am a certified geriatric care manager and licensed speech-language pathologist. My clinical focus has been dedicated to providing speech-language therapy for aging adults who experience communication, cognitive and swallowing difficulty resulting from conditions such as stroke, dementia, and progressive neurological disorders. As an experienced clinician in long-term care, I have served elderly patients residing in skilled-nursing units, nursing homes, inpatient and outpatient hospital settings, and through home health care. I currently own *Senior*Source LLC, a professional senior care consulting and geriatric care management practice in Stillwater, Oklahoma. This morning I would like to take several minutes to summarize findings and recommendations that are paramount to nursing home reform.

BARRIERS TO A "HOME" ENVIRONMENT AND QUALITY CARE

Many barriers to providing a "home" environment and quality care in nursing homes lie not with the people who provide the care, but lie within the care delivery "system" itself. These include:

1) <u>The Nursing Home Culture</u>

- **The present "culture" of long-term care institutions emphasizes care delivery that is institution-directed, in a hospital-like setting AS OPPOSED to resident-directed, in an environment that reflects the comforts of home.** For example, the *institution-directed* culture utilizes practices whereby residents' schedules and routines are designed by the institution and staff, and residents must comply. This is in sharp contrast to a "home-like", *resident-directed* culture that designs schedules and routines to reflect the personal needs and desires of each resident.

- **Traditional, institution-directed practices emphasize work as "task-oriented" and nursing assistants *rotate* assignments among residents, with limited opportunity to develop interpersonal relationships.** In a resident-directed model of care, staff duties are "relationship-centered", with emphasis on *consistent* assignments allowing nursing assistants to get to know residents on a personal level and care for them as individuals.

2) <u>Inadequate Nursing Assistant Education and Training</u>

- **Research studies clearly demonstrate the federally mandated 75 hours is not enough time to adequately teach the material students need to learn to become certified**

nursing assistants (CNAs). "Hands-on" clinical training in functional situations is also lacking.

- **Career ladders, designed to provide nursing assistants an avenue to increase their professionalism, to advance their skills, and to receive much deserved recognition are rarely adopted by nursing homes due to financial restraints.** Therefore, most nursing assistants do not have an opportunity for additional skill development in core competencies such as dementia care, nutrition, safety, and spirituality and dying.

- **Access to quality care for nursing home residents is restricted because of a crisis in recruiting and retaining qualified nursing assistants, who provide ninety percent (90%) of direct care.** Inadequate education and training, low wages, physical job demands, stressful working conditions, and high turnover rates all threaten care quality.

3) <u>Poor Utilization of Medicare Funding for Long-Term Care "Rehabilitation" Services</u>

- **Current Medicare guidelines impede access to and provision of appropriate and effective therapy services provided by skilled physical and occupational therapists, and speech-language pathologists.**

  a.) Historically, therapists' clinical involvement with treating older persons has been *reactive* (*post-crisis*) instead of proactive (preventative approach). Under present Medicare guidelines, in order for a nursing home resident to qualify for therapy services, he/she must demonstrate what is referred to as a "change in function." Often this change is identified as a *decline in medical condition* so severe the elderly person is unable to benefit significantly from traditional "rehabilitation" efforts.

  b.) *Restorative programs* designed to maintain a resident's functional skill level following discharge from therapy are often ineffective. The nursing home's restorative aid is responsible for implementing the programs. However, due to staffing shortages, the restorative aide is often asked by his/her supervisor to perform resident care duties instead. Therefore, residents who *are* able to benefit from skilled therapy often decline rapidly following discharge due to poor follow-through with an effective restorative program.

  c.) The current Medicare system does not reimburse for therapists' duties that are not part of direct patient care but *are CRUTIAL for quality care*. This includes attending/contributing to resident care plan meetings, conducting family conferences, providing staff education and training, and consulting with nurses and physicians. Many therapists are employed by rehabilitation companies who enforce strict productivity requirements. To meet these requirements, approximately 80% of therapists' services must be billable to Medicare. The above duties are crucial to quality care but are not billable to Medicare, lessen productivity and often go unfulfilled, resulting in poor utilization of highly educated and trained licensed therapists.

- **A *large percentage* of Medicare reimbursement for therapy services provided in nursing homes goes to pay NON-direct care providers, or the "middleman."** Examples of "middlemen" include rehabilitation company upper management personnel and office staff, Medicare claims officials, and fiscal intermediaries and carriers.

RECOMMENDATIONS AND REFORM

1) **Long-lasting improvements can only come from a *wholesale transformation* of the nursing home culture.** Facilities must be able to offer a "product" that consumers *want* to buy instead of identifying as a "last resort."

2) **Efforts should be directed toward building a service delivery system that values and enriches all who *live and work* within it**. *Residents* need to be recognized as individuals with unique needs and preferences, and be able to retain a sense of control over their lives and a voice in directing their care. Likewise, family member's involvement should be encouraged and seen as critical in the care process. *Nursing home staff* should work in an environment that allows them to thrive both individually and professionally. *Therapists* should provide services that effectively utilize their knowledge and skills and not be regulated by a system that allows companies to be more concerned with increasing their profit margins than in patient care.

3) **The provision of quality care in its truest sense will only be achieved by effectively resolving the direct care workforce *recruitment and retention* crisis. The workforce shortages should be remedied by:**

   a.) paying front-line workers respectable wages.

   b.) implementing adequate (not minimal) staffing levels to reduce caseloads and improve working conditions.

   c.) providing direct care workers the education, training, support and guidance so desperately needed to foster provision of quality care in nursing facilities.

4) **A service delivery model should be used that addresses the needs of long-term care residents from a truly geriatric approach, focusing on *preventive care* and *health promotion*.** Actions must include skilled therapists' and direct care workers' involvement in redesigning care processes, and these individuals must have an active role in the "community of care" for each resident.

5) **Traditional, "rehabilitation" services provided for long-term care residents should be REPLACED with individualized, resident-centered programs, for "every" resident, that targets *quality improvement*.** For example: **a.)** **Physical Therapists** should address safety issues with all residents through a comprehensive falls evaluation and management program, with emphasis on behavioral management resulting in less need for physical restraints and pharmacological treatments. **b.)** **Speech-Language Pathologists** should implement programs that address involuntary weight loss, safe feeding, dementia care and wandering/elopement. **c.)** **Occupational Therapists** should implement programs that maximize functional outcomes and improve quality of life by addressing continence issues, pain management, isolation/depression, and palliative/end-of-life care.

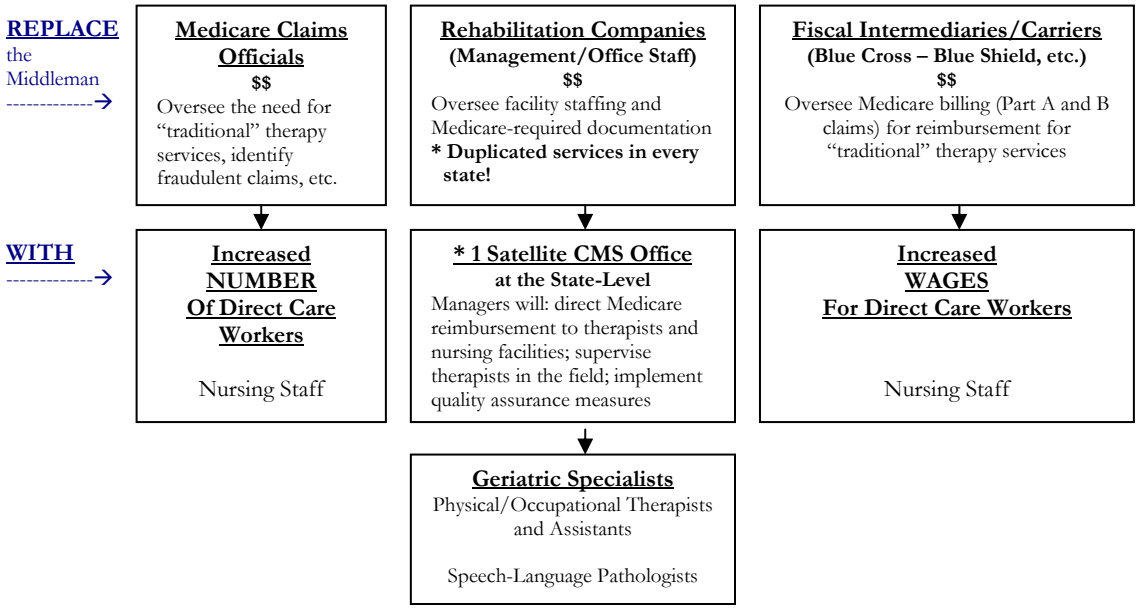
6) **Direct Care Workers in nursing facilities should receive hands-on, clinical training, supervision, support, and guidance from skilled therapists.** Demonstrating the ability to teach an individual a particular skill to achieve a desired outcome is one of the hallmarks of a truly effective clinician. For example: **a.)** **Physical Therapists** should teach direct care workers how to properly transfer each resident to prevent and/or reduce fall-related injuries and decrease work-related injuries. **b.)** **Occupational Therapists** should teach direct care workers how to assist each resident complete activities of daily living (e.g., personal hygiene,

dressing and feeding) while maximizing independence. **c.) Speech-Language Pathologists** should teach direct care workers how to communicate effectively with people who experience difficulty due to stroke, dementia or hearing loss; and how to provide effective nutrition and hydration care to reduce involuntary weight loss, dehydration, pressure ulcers, and complications with tube feedings.

7) **Taking a proactive, resident-centered approach to service delivery should *improve the quality of care* for residents and *lower Medicare costs* by** reducing hospitalizations and medical expenses due to potentially avoidable conditions such as falls, pressure ulcers, urinary tract infections and aspiration pneumonia. **Likewise, *facility costs should go down*** because with a reduction in staff turnover, less money will be spent on temporary agency staff, overtime and advertising. Work-related injuries and worker's compensation claims should be reduced because the number of nursing assistants to provide direct care will increase and the education and training with resident transfers will improve.

8) **CMS should restructure the Medicare reimbursement system for rehabilitation services provided in long-term care facilities by redirecting dollars currently being paid to *the middleman* (non-direct care providers) to a.)** employ a greater number of direct care workers, **b.)** pay these individuals higher wages, and **c.)** employ a limited number of (CMS-contracted) managerial staff at the state-level to manage/supervise therapists in the field and implement quality assurance measures for geriatric programs.

Modernized Reimbursement System for a Geriatric Service Delivery Model Designed to Improve the Quality of Care in Long-term Care Facilities



In closing, I strongly urge the White House Conference on Aging to include in its final recommendations the need for deep system change in the service delivery model utilized in long-term care facilities. I have provided specific, actionable, and cost-efficient approaches toward facilitating a "home" environment and eliminating barriers to quality care; such as transforming the nursing home culture, resolving the workforce staffing crisis, and restructuring the Medicare reimbursement system for rehabilitation services.

I would like to thank the committee for the opportunity to testify here today, and I will be happy to answer any questions.